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In this Issue . . . .

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Preserving Life

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Editor's note: Father Gerald Kelly, S.J., has covered the Catholic attitude regarding the ordinary means of preserving life and the extraordinary measures necessary to prolong existence in the Medico-Moral-Problems *series of booklets published by The Catholic Hospital Association. These publications are now in the process of complete revision and we have asked permission to print, in advance, the following as a combined article for* LINACRE QUARTERLY *readers. Inquiries continue to reach us regarding these topics and a reprint will be prepared for distribution at the Federation Exhibit during the A.M.A. convention this June. Questions pertinent to these subjects were the most frequently asked during the session last year.*

THE ORDINARY MEANS OF PRESERVING LIFE

Euthanasia usually implies the use of some positive means to end life: e.g., taking poison, a lethal dose of some drug, and so forth. But death can also be brought about in a negative way: i.e., by not taking or giving something which is necessary for sustaining life; and in some cases this failure to take or give what is necessary for preserving life is equivalently euthanasia. That is the general meaning of n. 22 of *The Ethical and Religious Directives for Catholic Hospitals* published by The Catholic Hospital Association: "The failure to supply the ordinary means of preserving life is equivalent to euthanasia." A complete explanation of this directive calls for an explanation of *ordinary* and *extraordinary* means of preserving life, as theologians use these terms, and also for an explanation of the duties of patients and doctors regarding the use of these means.

MEANING OF TERMS

Doctors and theologians are apt to attach different meanings to the terms, "ordinary" and "extraordinary," as J. E. Drew, M.D., and John C. Ford, S.J., pointed out in their article, "Advising Radical Surgery: A Problem in Medical Morality," *Journal of the American Medical Association*, Feb. 28, 1953, pp. 711-716. Thus, as regards physicians, Dr. Drew and Fr. Ford write: "To the physician ordinary signifies standard, recognized, orthodox, or established medicines or procedures of that time period, at that level of medical practice, and within the limits of availability. Extraordinary signifies, from the physician's standpoint, a medica-

ment or procedure that might be fanciful, bizarre, experimental, incompletely established, unorthodox, or not recognized."

Theologians use these terms in a different sense; and it is important to note this because the directive follows the theological meaning. As regards various hospital procedures, the theologian would say that *ordinary* means of preserving life are all medicines, treatments, and operations, which offer a reasonable hope of benefit for the patient and which can be obtained and used without excessive expense, pain, or other inconvenience. For example, suppose that a patient whose health is normally good has pneumonia. This patient is now facing a crisis; but from our experience we have every reason to believe that we can bring him through the crisis by means of certain drugs, such as penicillin, and the use of oxygen for a time. Once he passed the crisis he would be well on the way to complete recovery. Here we seem clearly to be dealing with *ordinary* means; for the use of the drugs and oxygen in these circumstances does not involve excessive inconvenience; and there is a very reasonable hope of success.

In contradistinction to ordinary are *extraordinary* means of preserving life. By these we mean all medicines, treatments, and operations, which cannot be obtained or used without excessive expense, pain, or other inconvenience, or which, if used, would not offer a reasonable hope of benefit. For example, consider a case like this. A young woman has a rare cardiac ailment. There is a chance of curing her with an extremely delicate operation; but it is only a chance. Without the operation, she may die on the table or shortly afterwards: but she also has a chance, though considerably less than an even chance, of surviving and of being at least comparatively cured. This operation seems to be a clear example of an *extraordinary* means of preserving life, especially because of the risk and uncertainty that it involves.

Another example. A patient, almost 90 years of age, has a cardio-renal disease and has been in a coma for two weeks, during which time he has received intravenous solution of glucose and some digitalis preparation. This coma is apparently terminal. In such a case, is the continued use of glucose and digitalis to be considered an ordinary or extraordinary means of preserving life? The answer may not be entirely clear and beyond debate; but I believe that moralists would generally say that, though the use of the glucose and digitalis would be ordinary means if it were merely a matter of tiding a patient over a temporary crisis, yet in the present case the actual benefit they confer on the patient is so slight in comparison with the continued cost and difficulty of hospitalization and care that their use should be called an *extraordinary* means of preserving life.

The Duty

Every individual has the obligation to take the ordinary means of preserving his life. Deliberate neglect of such means is tantamount

to suicide. Consequently, every patient has the duty to submit to any treatment which is clearly an ordinary means; and his doctor, as well as the nurses and hospital personnel, has the duty to use such means in treating the patient. To do less than this is equivalently euthanasia — as is stated in directive 22.

It should be noted, however, that the directive is here enunciating only a *minimum:* this is the least that must be done for any patient. As a matter of fact, there are some cases in which a patient might be obliged to use extraordinary means; and there are many cases in which the doctor is obliged to use them. In the next section I shall try to indicate some norms for the use of extraordinary means in the care of patients. For the present, it seems sufficient merely to state the fact that the use of extraordinary means is sometimes obligatory.

Historical Background

It is not always easy to distinguish between ordinary and extraordinary means of preserving life. I believe that the definitions I have given would meet with substantial approval by most moralists today; yet some might prefer to phrase them somewhat differently. For instance, one outstanding theologian suggests that ordinary means would include "the medicines, nursing, etc., usually adopted by persons of the same condition of life as the patient." This is perhaps a good working rule for most cases. I believe, however, that it should be considered as merely supplementary to the definitions I have given, because my definitions more explicitly include elements that are essential to the historical development of the terms, *ordinary* and *extraordinary* means of preserving life. The medical profession should know something of this history.

The moralists who coined the terms, *ordinary* and *extraordinary* means of preserving life, were deeply conscious (as Catholic moralist have always been) of a clear distinction between the duty of *avoiding* evil and the duty of *doing good.* One must, at all costs, avoid doing what is intrinsically evil; but there are reasonable and proportionate limits to one's duty of doing good. For example, the martyrs were not ordinarily obliged to seek out their persecutors in order to profess their faith before them; but when faced with the critical choice of either denying their faith or dying they were obliged to submit to death. The reason is that to deny one's faith in the one true God is intrinsically evil — something which may never be done, even to avoid torture and death. A modern example illustrating the same matter might be the problem of childbearing in marriage. Married people are not obliged to have all the children they possibly can, nor obliged to have children in the face of great inconveniences; but they are clearly obliged to avoid contraception because it is intrinsically evil.

With this distinction between doing good and avoiding evil in

mind, the old moralists approached the problem of preserving life. They were not disturbed by the problem of "mercy killing"; they know that suicide and murder are always wrong and that no inconveniences can justify them. But to preserve one's life is to do good; and the duty of doing good is usually circumscribed by certain limits. The moralists set out to make a prudent estimate of the limits of this duty. In other words, they wanted to answer the simple question that any good man might ask: "How much does God demand that I do in order to preserve this life which belongs to God and of which I am only a steward?" In answering this question, they discussed such practical, concrete things as expense, pain, repugnance, and other inconveniences.

Inconvenience

For example, regarding expense, they considered it obvious that a man would have to go to some expense in caring for his health. Yet he need not spend money or incur a debt which would impose a very great hardship on himself or his family, because this kind of hardship would be more than a "reasonable" or "moderate" care of health and therefore more than God would ordinarily demand.

And so of other things. The moralists spoke of great pain, e.g., the enduring of a serious operation in days when there were no effective anaesthetics. It took heroism to undergo such an ordeal; and the moralists prudently estimated that an individual would not ordinarily be obliged to submit to it. They spoke of other inconveniences, too: e.g., of moving to another climate or another country to preserve one's life. For people whose lives were, so to speak, rooted in the land, and whose native town or village was as dear as life itself, and for whom, moreover, travel was always difficult and often dangerous — for such people, moving to another country or climate was a truly great hardship, and more than God would demand as a "reasonable" means of preserving one's health and life.

The foregoing are merely examples of the way the older moralists considered the means of preserving life in terms of inconvenience. If the inconvenience involved in preserving life was excessive by reason of expense, pain, or other hardship to oneself or others, then this particular means of preserving life was called *extraordinary*. On the other hand, when no excessive inconvenience was involved, the means of preserving life would generally be considered *ordinary*.

Usefulness

There is one more point to be discussed before I can give a complete idea of the historical notions of *ordinary* and *extraordinary*. I can illustrate this point by an example taken from another section of moral theology: the duty of charity towards one's neighbor.

Suppose that I see my neighbor drowning, but that I am a very poor swimmer and should have very little chance of saving him. Am I obliged to make the attempt? Catholic moralists would say that I might be heroic to try, but that I

would have no strict obligation to do so. In giving such an answer, they are simply applying a sound principle of both philosophy and common sense, namely, that no one is obliged to do what is practically useless.

Moralists have applied this same principle when discussing the duty of preserving one's own life, especially by taking medicines, undergoing operations, and so forth. As a matter of fact, we know that some of these things help, and some do not; some offer great hope of success; others offer very slight hope. The old moralists realized this too; and they introduced this element of "hope of success" into their concepts of ordinary and extraordinary means of preserving life. A means was considered *extraordinary* if it involved excessive inconvenience *or* if it offered no reasonable hope of benefit. A means was considered *ordinary* if it did not involve excessive inconvenience *and* it offered a reasonable hope of benefit.

The foregoing are the main points that mark the development of the moralists' discussion of ordinary and extraordinary means of preserving life. We can apply them to the vast number of artificial life-sustainers now at the disposal of the medical profession by judging two elements, *convenience* and *utility*. A medicine, treatment, etc., is to be considered an ordinary means if it can be obtained and used with *relative convenience* and if it offers *reasonable hope of benefit*. When either of these conditions is lacking, the means is extraordinary.

It should also be noted that the moralists were primarily concerned with the duty of the individual (i.e., the patient), not his doctor. They thus chose the easier course, because the doctor's problem is much more complicated. The patient is obliged to use ordinary means; as for extraordinary means, he may use them if he wishes, but, apart from very special circumstances, he is not obliged to do so.

I have heard it said that the doctor's duty is exactly the same as the patient's. This is not correct. The doctor (as well as nurses and hospital authorities and personnel) must do not only what the patient is obliged to do but also what the patient reasonably wants and what the recognized standards of the medical profession require. I shall discuss these points in the next section.

It is important to note that, though the notions of ordinary and extraordinary remain the same, their applications can vary with changing circumstances. For example, major operations used to be considered extraordinary means of preserving life on two counts: first, because the pain was practically unbearable for most people; and secondly, because the outcome was often very uncertain, e.g., because of the danger of infection. Today we have means of controlling both the pain and the danger of infection; hence, many operations that would have been extraordinary in former times have now become ordinary means of preserving life.

EXTRAORDINARY MEANS OF PROLONGING LIFE

In the preceding section it was pointed out that, in terms of modern medical procedures, *extraordinary* means of preserving life are all medicines, treatments, and operations, which cannot be obtained or used without excessive expense, pain, or other inconvenience for the patient or for others, or which, if used, would not offer a reasonable hope of benefit to the patient. One example given was that of a very dangerous and uncertain operation; another was the use of such things as intravenous feeding to prolong life in a terminal coma. Still another example, culled from medical literature, is the case "when life can be somewhat prolonged by a gastroenterostomy or an enteroanastomosis," as mentioned by Walter C. Alvarez, M.D., in the *Journal of the American Medical Association*, September 13, 1952, p. 91.

In concrete cases it is not always easy to determine when a given procedure is an *extraordinary* means. It is not computed according to a mathematical formula, but according to the reasonable judgment of prudent and conscientious men. Granted such a judgment, the patient himself is not generally obliged to use or to submit to the procedure. He may, with a good conscience, refuse it except in special cases when a prolongation of his life is necessary: (a) for the common good, as might happen in the case of a great soldier or statesman; and (b) for his own eternal welfare, as might be the case when he has not yet had the opportunity of receiving the Last Sacraments.

Here I want to consider the duty of the doctor to use *extraordinary* means of preserving life. Under the term "doctor," I include not only the attending physician but also all who assist him in the care of the patient, i.e., nurses and hospital personnel. To avoid unnecessary complications we shall limit the discussion to patients who are in some sense "paying" patients, i.e., those whose expenses are being paid by themselves, their relatives, an insurance company, etc. In other words, we are excluding the purely charity case in which the medical care is given *gratis*.

The Patient's Wish

How is the doctor to judge whether he is obliged to use an *extraordinary* means? The first rule for judging is indicated by Dr. Alvarez when he speaks of somewhat prolonging life by a gastroenterostomy or an enteroanastomosis: "*the wishes of the patient* should be ascertained." The words I have italicized contain the first rule concerning the doctor's duty: he must do what the patient wishes. It is the patient who has the right to use or to refuse the extraordinary means; hence, it is primarily the patient who must be consulted. Obviously there are many cases in which it is impossible to consult the patient, e.g., when he is delirious or in a coma, or when he is a small child. In these cases the right to make the decision is vested in those who are closest to the patient, i.e., husband, wife, parents, guardians. Thus, Dr. Alvarez rightly says that the wishes of the

family must be consulted when there is question of efforts at resuscitation by means of oxygen and "endless injections of stimulants" in the case of an old person who is close to death. I might add here that the relatives do not make this decision precisely in their own name, but rather as representing the patient; hence, they should try to determine what he would reasonably want done under the circumstances. (Perhaps some further distinction should be made regarding relatives and guardians who merely administer the property of the sick man and those who pay his medical bills out of their own money; but I believe such a distinction is not pertinent to our present discussion.)

There are cases, no doubt, when consultation with the patient or the relatives would be impossible, or inadvisable, or useless: e.g., when they would not understand the issues or are too much distraught to make decisions, and so forth. In such cases, it seems to me, the doctor should follow the plan previously suggested for the relatives: that is, try to make a prudent estimate of what the patient would reasonably want if he could be asked. This would mean that the doctor would do what he sincerely judged to be for the best interests of his patient. If other means are lacking for determining this, the golden rule should be helpful. What would the doctor himself want if he were in the patient's condition?

Strict Professional Standard

Thus far we have considered only the doctor-patient relationship; and what has been said may be reduced to this: the doctor should follow the expressed wishes of the patient or his representatives; and when their wishes cannot be explicitly ascertained, he should do what he thinks the patient would want or what he sincerely judges to be for the patient's best interests. Even these relatively simple rules are sometimes difficult to apply; but the problem of using or not using *extraordinary* means may be even further complicated by the question of "professional standards."

When I speak of professional standards, I mean this: is there a line of conduct dictated by his profession itself which requires the doctor to take means of prolonging life that might not be required merely by the physician-patient relationship? To make this problem more concrete, let me say that in discussions with conscientious physicians I have observed two different professional standards in this matter.

One group of these conscientious physicians believes that the doctor's duty is to preserve life as long as he can, by any means at his disposal, and no matter how hopeless the case seems to be. We can call this the *strict*, or *extreme*, professional standard. The doctors who uphold this standard admit the right of the patient or his representatives to refuse *extraordinary* means; but they think that, insofar as the judgment is left to the doctor himself, he must simply keep trying to prolong life right to the very end.

The following of this strict

standard has several advantages. In the first place, it gives euthanasia the widest berth possible. Secondly, it completely avoids defeatism. These doctors not only keep trying to conquer a disease, they also keep trying to save the individual patient. And there is no doubt about it: they can sometimes show us cases in which a former patient is now alive and well two, three, or many years after he was supposed to be "hopeless." Finally, strict though it is, this standard is easiest on the doctor's own conscience because he is never forced to make the painful decision to cease using intravenous feeding, oxygen, and so forth, in the case of a dying patient.

Moderate Standard

As I said, there are many conscientious doctors who follow the *strict* standard to which reference has just been made. But there are others, equally conscientious, who believe that a more *moderate* standard should be followed. These doctors try to effect a cure as long as there is any reasonable hope of doing so; they try to preserve life as long as the patient himself can reap any tangible benefits from the prolongation. But they also think there is a point when such efforts become futile gestures; and they believe that at this point the sole duty of the doctor is to see that the patient gets good nursing care and that his pain is alleviated.

The advantages of the strict standard are the disadvantages of the moderate standard. The doctors who follow this latter standard certainly have no sympathy for euthanasia; yet their failure to take certain means of prolonging life might at times create the impression of favoring euthanasia. They are not defeatists; yet, through their willingness to consider some cases hopeless according to present medical knowledge, they might occasionally lose a battle that the stricter doctors would win. Moreover, their occasional decisions to discontinue stimulants or artificial feeding are seldom made with perfect mental peace. Such a decision easily generates worry.

But it must be admitted that the moderate standard is not without its advantages. For one thing, it seems to be very much in accord with the traditional policy of Catholic theologians of interpreting obligations according to a reasonable limit — as we have seen, for example, in their explanation of the individual's duty of caring for his own health.

The moderate standard also seems to square with a good Christian attitude. I once asked the mother superior of a home for incurable cancer patients whether they used such things as intravenous feeding to prolong life. She replied that they did not. They gave all patients devoted nursing care; they tried to alleviate pain; and they helped the patients to make the best possible spiritual preparation for death. Many very good people with whom I have spoken about this matter think these sisters have the right idea — "the good Christian attitude toward life and death," as they call it. This is really an exemplification of the moderate standard.

Finally, it seems evident that the moderate standard is less likely to impose excessive burdens on the patient's relatives. Relatives often endure terrific strain and undergo great expense while life is being prolonged by artificial means; and in some cases — e.g., the terminal coma — very little good seems to be accomplished. The moderate standard spares them some of this strain and expense.

Conclusion

I have dwelt at some length on these two views of conscientious physicians because I wanted to make it clear that as yet there is no clear-cut professional standard regarding what I might respectfully call "the fine points" of care of the dying. I may add that among moral theologians a somewhat similar condition prevails: up to a certain point duties are clear and there is agreement on what must be done; beyond that point the rules of obligation become obscure and there is room for differences of opinion.

Some time ago, I published in the Jesuit quarterly, *Theological Studies* (June 1950, pp. 203-220), a rather lengthy article entitled "The Duty of Using Artificial Means of Preserving Life." The purpose of this article was to stimulate discussion among theologians concerning what seemed to be a cardinal problem in modern medical practice. Later, in the same magazine (December, 1951, pp. 550-556), I published a shorter article entitled "The Duty to Preserve Life," which included the points that had been brought out in our discussions. This second article concluded with a statement which substantially expresses the minds of many competent theologians. Perhaps it will help to reprint it here. It runs as follows:

1. It is not contrary to the common good for a doctor to admit that a patient is incurable and to cease trying to effect a cure. But it would be contrary to the common good to cease trying to find a remedy for the disease itself.

2. As long as there is even a slight hope of curing a patient or checking the progress of his illness, the doctor should use every probable remedy at his command. The common good demands this rule of conduct for the doctor; and it should be followed as long as the patient makes no objection. The patient, however, is entitled to refuse any treatment that would be extraordinary.

3. When a doctor and his consultants have sincerely judged that a patient is incurable, the decision concerning further treatment should be in terms of the patient's own interests and reasonable wishes, expressed or implied. Proper treatment certainly includes the use of all natural means of preserving life (food, drink, etc.), good nursing care, appropriate measures to relieve physical and mental pain, and the opportunity of preparing for death. Since the professional standards of conscientious physicians vary somewhat regarding the use of further means, such as artificial life-sustainers, the doctor should feel free in conscience to use or not use these things, according to the circumstances of each case. In general, it may be said that he has no moral obligation to use them unless they offer the hope of some real benefit to his patient without imposing a disproportionate inconvenience on others, or unless, by reason of special conditions, failure to use such means would reflect unfavorably on his profession.

All of us who sponsored this statement realize that it may need improvement and further clarification. Even as it stands, however, it should help doctors to solve these difficult cases with a realization of a certain degree of liberty of judgment and with a consequent peace of conscience.

Doctor! . . .

Is There a Father in the House?

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THE VERBAL switch in the title is not a little trick made just to be facetious. It states a real problem which needs a realistic solution. I am hoping by the title not only to catch your eye, but also to hold your mind and encourage you to look into your conscience.

The traditional call for a doctor indicates a need; a need at once urgent and immediate, demanding the special care of a medical man. Here, too, is a call also indicating a need — a need which is also pressing, demanding the special care of a dedicated man. This is the doctor's *own* family calling . . . calling him to come home, because of the desperate need of a husband and a father. It can be a very pitiful, sometimes tragic, plea — "We need a father in the house!"

This is not a simple problem for which there is any easy solution. This is not a question of "close the shop and go on home," or "don't delay in the tavern after work," or "cut down on the business trips and stop entertaining the clients at night." Nor am I concerned with the type of man who could, but just doesn't want to be home, one who is looking for excuses to stay away. I am talking about a man who is good, honest and sincere, one who loves his wife and children and wants to be with them. He feels the lack of time he has with them as keenly as they do. But he is a doctor and he just can't seem to get home because there are too many other people consuming his time.

Obviously, then, the doctor is faced with a basic conflict of obligations. This is not just an apparent conflict. It is real, because the two-fold obligation of the doctor is serious and binding in conscience. He has an obligation to his family which he assumed freely and willingly when he received the sacrament of matrimony. More than just providing food, clothing and education, he owes *himself* as the head of the house, giving love and affection and assistance to his wife in caring for and training the children. He cannot do this and be absent from them the greater part of the time.

He also has an obligation by reason of his profession to his patients. He is a doctor, again, because he freely and willingly chose a medical career. When he be-

came qualified to practice medicine, he sincerely dedicated himself to the care and cure of those who are ill. He is obliged not only to provide this care to those who seek it and who place themselves in his hands, but he must also necessarily continue his medical education, studying and appraising himself of new and approved procedures in the field.

Here is the conflict. How can he fulfill both of these serious, time-demanding obligations during a twenty-four hour day and a seven-day week?

Let us analyze this conflict a little further. Here is a man — honest, sincere and mature. He chose a medical career, not only because he wanted to be a physician, but because he also sincerely felt that this was what God wanted him to be. He thought long about it, prayed frequently and considered it carefully. When he decided, it was the same kind of a decision that a young man makes when he becomes a priest. This is a vocation — to be a doctor. Through his long training he learns the meaning of and accepts the obligations of his vocation. He knows that this vocation will make demands on his time and talents, that he will often have to defer his personal wishes and desires in favor of his patients. He accepts and is sure that with God's help he will be able to fulfill his obligations to his vocation.

However, either before he has finished his training in medical school or frequently it happens before he has finished his internship and residency program, he has made another choice and it is also the choice of a vocation. He has chosen the marriage state and this, too, after prayerful consideration and with even more dependence upon God. Thus, he has assumed further obligations which are sacred and solemn, the primary one of which is to bring children into the world, care for them and prepare them for eternity. Both of these obligations are assumed when the surrounding circumstances make it most difficult. As an intern or resident, there is the constant "on call" schedule. If not that, then there is the struggle to establish a practice and try to live at the same time. He has to take everything and anything he can, from insurance examinations to industrial health clinics, in order to subsist.

During this time, the family is increasing. The wife is alone so much of the time her tasks become more and more wearisome and the babies seem to be burdens rather than blessings. When the father is home, he is so tired he just wants to rest and be left alone, or he has to study or read. The result is increasing strain and tension which releases itself in mutual blame and exaggerated emphasis on each other's faults.

As time goes along, the problems remain, but for opposing reasons. After a few years, the doctor's practice has grown extensively and he is so busy that he still isn't home very much. The mother is still deciding the home problems and although she now has help with the housework, she still enjoys only a short vacation now

and then when there is a medical convention somewhere.

What happens then? Generally a very vicious family circle. The doctor's hours become irregular; when he does come home, the wife is angry; she is unpleasant and blames him. He must continue to be a doctor and to avoid the constant bickering, he escapes into his practice and becomes that "wonderful Dr. ....," who is always in his office or at the hospital — or at the club. Or perhaps it is the busy surgeon who has operations scheduled every morning and so he must retire at ten or eleven, which is too early to allow for a movie, or an evening party must be interrupted. So the wife, whose social life is much restricted all too frequently, must go home early.

And so it goes in one way or another. The doctor is away from home so much that there just is not time enough to be a good husband and father. What's the solution? Once all of this is clearly and mutually recognized by the doctor and his wife and soberly discussed without rancor and with patience and understanding, then some practical conclusions can be formed and practical applications made.

First, to resolve the problem of these conflicting obligations, it is vitally necessary to remember and to realize fully that these obligations derive from and are subject to an even more fundamental obligation of the man, as father and doctor, to God. Thus, it is absolutely essential to set up a right order of values. What comes first? Can the conflicting obligations take a definite order of precedence? The answer is — yes. The order is: God — Family — Medicine. God comes first, because He is the ultimate End; the final goal of all of life. The family is second to God. This is the primary vocation — to be a father, to have a family. This is the means here on earth whereby he is going to attain his final goal and ultimate End, God. And following these in order is medicine which is merely a means of helping him to attain the other two. Medicine is not an end in itself. It is a vocation within a vocation, but the practice of medicine must be a help to his being a father, not a hindrance — or else the doctor fails in both.

This does not automatically resolve the conflict in practice, but it should solve the conflict in the mind, which then should be put into practice. The family, as a unit, must see the dual obligation of the father-doctor and all must accept it in the spirit of mutual sacrifice! There is the key to the problem — sacrifice. To be a doctor demands sacrifice. To be the wife of a doctor demands sacrifice. To be the children of a doctor demands the same. But if all are making these sacrifices willingly, then the very sacrifices will draw them together as nothing else could. For the obligations with their sacrifices are also privileges. The doctor and his family are set apart. They are all dedicated people. So when the doctor can't get home or is called away in the middle of the birthday party or has to cancel a vacation because of an emergency oper-

ation, the wife and children know he wants to be with them but that he must sacrifice them. They, in turn, sacrifice him to the needs of others. Thus it is that when they are together, it means more to them and they enjoy one another more, because it is more deeply appreciated.

At the same time, the doctor should make a real effort to find ways of making up to his family for his unavoidable absence from them. He should at times sacrifice himself for them as he so readily does for his patients. Or he may have to refuse the demands of an unreasonable patient for the sake of his family. It may even eventually come to the point where he will be obliged to limit his practice to allow more time with his family. One very practical way for the doctor's family to be together more often is for the doctor and his wife to entertain as a family. Include the children in the visits with friends and encourage them to bring their children when they return the visit. There are so many couples who know each other so very well, but their children are not acquainted.

And so it is a matter of putting first things first . . . God, Family, Medicine. In this age of increasing emphasis on the specialist, the doctor should apply himself to the greatest specialty of them all — that of being a good father. The medical profession has grown away from the family doctor. What is needed now is to bring the doctor back to the family — his own. Yes, doctor, there must be a father in the house!

Father Roche, ordained in 1943, is a member of the Congregation of the Mission, the Vincentian Fathers. For three years he served as Catholic Chaplain at St. Louis City Hospital and has been with De Paul Hospital since July of 1956. Acquaintance with many internes and residents as well as staff doctors prompted this sympathetic approach to a problem which certainly needs thoughtful consideration.

TRAVEL ASSISTANCE AVAILABLE . . .

The well-known O'Scannlain & English Travel Service, 62 W. 46th St., New York 36, N. Y. has been appointed the official Travel Agency for the Jubilee Celebration of the Federation of Catholic Physicians' Guild in New York, June 5.

The Agency belongs to ASTA (American Society of Travel Agencies) and WATA (World Association of Travel Agencies), and consequently has excellent facilities for handling the Jubilee Celebration. It will arrange transportation for groups and individuals, to and from the Convention of the A.M.A. scheduled in New York City June 3-7, hotel accommodations, tours to Bermuda and the New England States, and other interesting places, and excursions in New York City and vicinity.

Mr. Jack Lampe will be in charge of the Agency's arrangements for the Jubilee Celebration. He will cooperate closely with the Jubilee Committee in order to give the Guild members maximum service. We urge you to inform Mr. Lampe as early as possible as to their service requirements. The Agency and Jubilee Committee will mail further information regarding plans for the Jubilee Celebration.

The Thomas Linacre Award

The Executive Board of The Federation of Catholic Physicians' Guilds at the winter meeting, 1956, voted to sponsor *The Thomas Linacre Award.* This will be made annually to the Catholic physician contributing an article to LINACRE QUARTERLY judged by the Editorial Board to be most valuable in content to promote the interests of the journal in its efforts to express opinions in the light of Catholic teaching as applied to medical practice.

The first Award will be made at the Silver Jubilee Celebration of the Federation in New York City on June 5. The choice will be made from among the articles contributed by Catholic physicians during the past five years. Subsequent awards will be made each June at the annual meeting of the Federation. The recipient will be presented a medal suitably engraved and the physician will be the guest of the Federation on that occasion.

This is meant to encourage Catholic physicians to write for our journal. Any who feel they have a message to contribute are urged to apply pen or pencil to their thoughts and send the results to Reverend John J. Flanagan, S.J., Editor, THE LINACRE QUARTERLY, 1438 So. Grand Blvd., St. Louis 4, Missouri.

The "Gabriel Group"

Alice Holoubek, M.D.

Shreveport, Louisiana Catholic Physician's Guild

Members of the Shreveport, Louisiana Catholic Physicians' Guild are assisting a most worthy project in their community. Dr. Alice Holoubek has sent us an account of the activities of the "Gabriel Group" that helps expectant mothers. Lectures are given, followed by discussion periods. The interest of Dr. Holoubek in this work is very evident, and we are quite certain that the cooperation of her fellow-Guild members is a reflection of her own efforts. But let us give you the story in her own words.

It is difficult for married couples of today to live up to their Christian ideals at best. In a predominantly non-Catholic community such as ours, the materialism of the environment certainly increases the difficulty. The attitude of the neighbors — the change of attitude toward the birth of each additional child — present formidable problems. In an effort to aid in the combat in an active way, groups of expectant mothers have been gathering to discuss and, we hope, to grow spiritually in their attitude toward their families. In addition, more formal talks are given to them on the normal functions and development of mother and child during this period of pregnancy.

There are many errors to be overcome in the purely natural field. Our young mothers receive most of their knowledge of pregnancy and childbirth from novels, movies, experiences of friends, and from their mothers. The first two sources usually present the difficult and heart-rending aspects, as each of us well remembers. As to real life experiences, these are often related inaccurately; the most unusual and bizarre events are the better remembered, and very often the informer really has very little true knowledge to impart. So on a purely natural level, instruction of normal physiology should tend to allay fear and ignorance, which are physical as well as psychical detriments to natural childbirth.

However, always of much greater importance, is instruction and emphasis on the spiritual glory of bringing a child into the world, a child whose soul will live and love and serve God for all eternity, a child whom God has co-created with the human parents, a child who carries in his body the potentiality of the future. A true understanding of this tremendous reality should make the most worldly individual regard parenthood reverently.

The families of our parish are of a fairly consistent economic level and have no need of the Public Health type of pre-natal instruction and care. However, in parishes where there are some who do not enjoy economic ease, this discussion can be adjusted to cover this aspect and be very adequately supervised and conducted by Catholic nurses engaged in Public Health activities.

Practically, the groups have been meeting about once a month for four meetings. At the first gathering, our Pastor introduces the series and emphasizes the spirituality of motherhood. Following his departure, as a doctor and a mother, I give a brief simple explanation of the physiology of menstruation. The second lecture, given by a prominent obstetrician, describes conception, heredity, fetal development, RH factor, and cesarean sections. At the third meeting, our Pastor is again with us, presenting the teachings of the Church as to the dignity of life and the Catholic teaching on birth control, abortions, and surgical operations of the generative organs. Also, another Catholic doctor describes the physiology of pregnancy and labor. The last meeting is a panel discussion by well-known and loved Catholic mothers of the community who discuss ways they have found effective in making Catholic teachings and especially the Liturgy, a part of their family life.

It is suggested that Guilds assisting with Cana activities in their communities might well include this "Gabriel Group" project in their program.

For the Good of Humanity . . .

IGNAZ PHILIPP SEMMELWEIS

THIRD IN our series of Catholic men of science, a word portrait of Ignaz Philipp Semmelweis adds an account of a dedicated doctor whose life became a gallant and bitter fight to rescue mothers and their newborn babies from ever-waiting death. Born July 1, 1818, the fourth son of a German merchant, he became a medical student at Vienna in 1837. After he had taken a philosophical course at Pesth, he continued his medical studies there, obtaining his degree in medicine at Vienna in April, 1844, as obstetrician in August of that year, and as surgeon in November of 1845. In February 1846 he was made assistant at the first obstetrical clinic of Vienna.

Early in his career Semmelweis, a brilliant young interne at the famed Vienna hospital made the shocking discovery that thousands of women were dying at childbirth because of the unhygienic methods of the physicians who attended them. He asserted that this condition among lying-in women was caused by infection from the examining physicians, who had previously made pathological dissections, or who had come into contact with dead bodies without thorough cleansing afterwards. After he had introduced the practice of washing the hands with a solution of chloride of lime before the examination of expectant mothers, the mortality sank from 18 per cent to 2.45 per cent. He also soon formed the opinion that not only infection from septic virus caused puerperal fever but that it also came from other causes of putridity.

When he broached his theory, Semmelweis was at first ridiculed — and then slandered and persecuted. His dislike of public speaking or of writing was probably the reason why his views were misunderstood. Many scholars, among them the doctors of the Academy of Paris and even Rudolph Virchow at Berlin, regarded him unfavourably. The petty persecution and malice of his opponents excited in Semmelweis a sensitiveness that increased from year to year. He was ever filled with hot conflict and fairly burst with the courage of a man with a true cause such as this; the appalling loss of lives, the indifference and neglect around him, were deep anguish to him.

The first account of his discovery was published by Professor Ferdinand Hebra in December, 1847, in the *Journal of the Imperial and Royal Society of Physicians of Vienna* (December, 1847), followed by a supplementary statement from the same physician in April, 1848. The following year, Professor Josef Skota delivered an address on the same subject at the Imperial and Royal Academy of Sciences. Unfortunately, Semmelweis had neglected to correct the

papers of these friends of his, and thus failed to make known their mistakes, so that the inference might be drawn that only infection from septic virus caused puerperal fever.

It was not until May 1850 that he could bring himself to give a lecture on his discovery before the Society of Physicians; a month later he followed with a second one. The medical press noticed these lectures only in a very unsatisfactory manner. He was crushed but in time his zeal returned. In October he became lecturer on obstetrics in Vienna. A few days after the appointment, for reasons unknown, he removed to Pesth where he was made head physician at the hospital of St. Roch and in 1852 was appointed regular professor of theoretical and practical obstetrics.

His theory would not be accepted, though, and with each succeeding "betrayal" of his work, as he felt denial of his discovery to be, mental disturbance became more evident. Heart-broken at the deplorable conditions prevailing and becoming worse, when his instructions were disregarded, he finally succumbed but not before he had made one final attempt to reach the world outside, having failed within. His mind was failing, but one morning before he was taken to the public insane asylum near Vienna, he stole off to a printer. He wrote busily. He commanded his intellect. He handed what he had written to the printer. "Tomorrow!" was the command. When the printer protested that he could not prepare the circulars in a day, Semmelweis paid him substantially to work through the night. Next morning early he crept from the house. He went directly to the printer. The man tiredly handed him a huge pile of circulars. They were printed in bold letters. The words were: **"Young men and women! You are in mortal danger! The peril of childbed fever menaces your life! Beware of doctors, for they will kill you! Remember! When you enter labor unless everything that touches you is washed with soap and water and then chlorine solution, you will die and your child with you! I can no longer appeal to the doctors! I appeal to you! Protect yourself! Your friend, Ignaz Philipp Semmelweis."** He put the bundle under his arm. He went out into the streets of Pesth. He ran to every young man, every young woman. He pressed his handbills on them. He would not be denied. They were gone. He had given away the last handbill. He went home, and then they took him to the asylum. His friends Bathory and Hebra were with him. Reluctantly they left him there. "There is a great man," said Bathory. "There is the greatest man we will ever know. There — in that asylum. And we are not worth it. We are none of us worth it." "No," replied Hebra, "it is probable that we are wholly maimed, blind, imbecilically cruel, ungrateful, that the thoughts by which we live make our very presence here on earth fantastic. And yet — I think we will always have men like him. We don't deserve it but what we are composed of is shining and indomitable. It is not shoddy, and it is wholly pure. It

is the cell which is eternal, beyond good and evil, the mortal and immortal symbol of the Almighty. And because of this the covenant will continue and the world and our petty thoughts which people it will continue to receive redeemers. And now this sweet and gentle and bewildered and raving man bears the burden of what we are not. Now he stumbles. Now he carries the cross. But to the end of time Medicine will bear this guilt and the human race will share the burden and the disgrace." From a bad gash in his finger, blood-poisoning developed and a month after he had been admitted, Ignaz Philipp Semmelweis died. Though his mind had failed, in one last lucid moment he whispered, *"I will never stop . . . no . . . never."* The date was August 13, 1865.

Though it was hard for Semmelweis to write, he published his work "Die Aetiologie, der Begriff und die Prophylaxis des Kindbettfiebers" (Vienna), in which he bitterly attacked his supposed and real opponents. He was not rejected by all. The *Etiology* had gone out into the world. Some praised him and hope had been raised for awhile, but when Virchow, the man to whom all the world of medicine looked with reverence, said coldly that childbed fever was caused by erysipelas and inflammation of the lymph glands, it fled. Another claimed, "The strictest cleanliness is of little use in preventing such colossal outbreaks of childbed fever as we experience here [Munich]. The doctrine of Semmelweis is one-sided, narrow, and erroneous."

His doctrine was ignored and misrepresented for years after his death. By 1890, as the older men died and young men replaced them, his theories began to spread, to become universal.

In 1891 a Hungary suddenly conscious of her greatest son took his body to Budapest for burial over the strenuous protests of Austria and Germany, where it now was claimed that the "Pesth Fool" was a German.

In 1906 a statue was unveiled in his honor in the city of his birth.

In the world today puerperal fever has by no means disappeared. But the children and the mothers his doctrine saved, the great men and women who live because he died, are as countless and unimaginable as the waves of the oceans.

Sir William Joppa Sinclair, Professor of Gynaecology and Obstetrics, University of Manchester, has paid this tribute: "It is the doctrine of Semmelweis which lies at the foundation of all our practical work of today. Through all the details of prevention and treatment, the temporary fashions and the changes of nomenclature, the principles of Semmelweis have remained our steadfast guide. The great revolution of modern times in Obstetrics as well as in Surgery is the result of the one idea that, complete and clear, first arose in the mind of Semmelweis, and was embodied in the practice of which he was the pioneer . . . ." And Joseph, Lord Lister, Professor of Surgery, Kings College,

London, declared, "Without Semmelweis my achievements would be nothing. To this great son of Hungary Surgery owes most."

For the good of humanity, Semmelweis himself wrote, "When I with my present convictions look back upon the Past, I can only dispel the sadness which falls upon me by gazing into that happy Future when within the lying-in hospitals, and also outside of them, throughout the whole world, childbed fever will be no more . . . But if it is not vouchsafed me to look upon that happy time with my own eyes, from which misfortune may God preserve me, the conviction that such a time must inevitably sooner or later arrive will cheer my dying hour." He did not see results then, but the world knows now.

Books Received . . .

Medical Ethics, Charles J. McFadden, O.S.A. Philadelphia: F. A. Davis Co., 1956. Pp. xix + 491; $4.25.

The main change in this fourth edition of Father McFadden's book is the addition of a chapter entitled "Man's Life — His Duty to Preserve It." In the earlier editions, many references were given at the conclusion of the chapters. For good reasons, explained in the preface, the author has decided to drop these references. Other changes consist of a re-arrangement of some material and the use of new data on various topics. Readers of THE LINACRE QUARTERLY no doubt realize that we now have a revised edition of *Ethical and Religious Directives for Catholic Hospitals.* It would be well to note, therefore, that Father McFadden's book still has the text of the old *Directives.* Those who use his book for classroom purposes should call attention to this and should, if possible, provide their students with the revised edition of the *Directives.*

The Morality of Hysterectomy Operations, Nicholas Lohkamp, O.F.M. Washington: Catholic University of America Press, 1956; pp. xi + 206; $2.25 [paper].

This is a doctoral dissertation. After giving the history of the operation and the moral principles that should govern it, Father Lohkamp considers practically all the possible indications for hysterectomy, cites medical authorities concerning its need or value, and then gives a moral appraisal of each case. Unfortunately, the author never gives a summary of these appraisals. A concluding chapter deals with the reasons and remedies for unnecessary hysterectomies. There is a glossary of medical terms, a bibliography, and a good index.

Religion and Medicine

John J. Lynch, S.J.

Professor of Moral Theology, Weston College
Weston, Mass.

In mid-December the Medical Society of the County of Kings and the Academy of Medicine of Brooklyn sponsored a panel discussion on religion and medicine. Father John J. Lynch, S.J., our consultant on medico-moral problems, was invited to participate, presenting the Catholic viewpoint. Other panelists were Rev. Dr. Dwight J. Bradley, Counsellor, The Associated (Religion and Medicine) Counselling Service, and Rabbi Ralph Silverstein, Temple Sinai (Arlington Temple), Brooklyn, New York, imparting the Protestant and Jewish attitudes. Father Lynch's remarks are published here and will appear in the ***Bulletin of the Brooklyn Medical Society.***

Ordinarily it is a breach of good taste for a platform speaker to make reference to his own qualifications. But may I, without apology, refer briefly to my limitations? I am not a psychologist; I am not a psychiatrist; and therefore I am not competent to express a professional opinion as to the impact which religion exerts as a therapeutic agent in the practice of medicine. If religion be understood in terms of a personal faith, i.e., in terms of one's own intellectual convictions with regard to the existence and nature of God and with regard to his own relationship with that God, I am not prepared to expound an empirical psychology which would define and evaluate religion's role as an adjunct to medicine. That type of discussion is properly reserved to the experts in a field other than my own.

Since I am a moral theologian, with something of a predilection for the problems of medico-morality, I feel constrained, justified, and content to restrict my formal remarks to some of the moral aspects of medicine. That, too, is a legitimate facet of the manifold relationship which religion bears to medicine.

For the word "religion" has come to have many legitimate meanings. The term is often understood as synonymous with the creed of a particular religious denomination; it is sometimes predicated of one's personal beliefs with regard to God; sometimes it is applied to emotional experiences, i.e., to one's emotional reactions to that personal concept of deity. But understood in its strict and technical sense (and admittedly I am defining the term in the light of scholastic philosophy and theology), religion is a moral virtue which inclines human nature to grant to God the reverence and honor that is due Him as the Supreme Being. Therefore our duty of obedience

to God's will is a primary aspect of religion understood in that sense, and is the *raison d'être* of any legitimate system of natural ethics or moral theology.

Only the atheist or the agnostic will quarrel with the concept of God as Supreme Being. Only the atheist or the agnostic — or perhaps, too, the anarchist—will seriously question the duty of obedience we owe to God, if and when we become aware of His intention to oblige us to a particular mode of action. So when the sincere Jew and Protestant and Catholic differ with one another as to conscience obligations, it is not because any one or other of them denies our subjection to God's will. Rather it is because we do not always agree as to what precisely God has expressed as His will for us.

That is as true of medico-morality as it is of morality in general. Because the doctor makes himself professionally responsible for human life and bodily integrity, he cannot fail to recognize — unless he be completely godless — that he thereby necessarily assumes special obligations for which he is answerable to God. Will anyone, for instance, deny that the commandment, "Thou shalt not kill," should have more practical significance for the physician than it need have for the cloistered nun in her convent? I am sure we can all agree that men in general are subject to God's moral law as expressed, for example, in the Ten Commandments; and that at least some of these Commandments have special application to the practice of medicine. If we could not agree to that minimal extent, then the presence here of a moral theologian would be a consummate waste of time for all of us.

It is only when we get involved with the more recondite implications of such a commandment as "Thou shalt not kill," that we begin to encounter disagreement as to conscience obligations for the medical profession. Such disagreement need not necessarily imply that some doctors are repudiating either God or His right to oblige us. Rather it is indicative of the extreme difficulty at times in discerning with any great degree of certainty to what extent and in what detail God has de facto obliged the physician in the exercise of his profession. But differences of opinion there are. Jew will differ from Protestant and Protestant from Catholic on many of the moral issues of medical practice. Precisely for that reason, I presume, are we three sharing this platform tonight.

It would be the grossest sort of discourtesy on my part to inject into a discussion such as this any spirit of controversy, any polemical note whatsoever. I have a personal distaste for religious controversy and decline to indulge in it. My purpose — and please trust my sincerity — is not to argue the issues of medico-morality; it is not to evangelize; it is merely to inform. May I then present myself as a limited source of information as to the Catholic position in this sphere of medical morality?

I have always believed that from a purely professional standpoint, merely as a matter of professional

competence and integrity, every doctor should understand and respect the conscience convictions of his patient, even though the doctor himself in all sincerity may differ. If by virtue of his office the physician is irrevocably committed to the best total interests of his patient, I simply do not see how the doctor can, in professional integrity, hold in contempt, or even disregard or be ignorant of, the conscience convictions of his patient, insofar as those convictions pertain to diagnostic or therapeutic measures.

Furthermore, it is my own opinion that many of our disagreements on medico-morality are due to nothing more than misunderstanding, and that mere information can suffice to dissipate much of that misunderstanding. Perhaps, for example, we Catholics sometimes occasion the impression that we consider ourselves as having a monopoly on moral principles and moral practice in the field of medicine. Certainly that is not and should not be the attitude of informed Catholics. I have met many a non-Catholic doctor whose moral principles and practice are just as orthodox as we consider ours to be. And I believe it to be the rule rather than the exception that the physician who is professionally honorable will, to the best of his knowledge, at least respect the consciences of his Catholic patients, regardless of his own convictions at times to the contrary.

At the professional level of medico-moral theorizing, I have been able to read with a good deal of admiration writings of such men as the Reverend Das Kelley Barnett of the Episcopal Seminary of the Southwest[1] and the Reverend George Christian Anderson, presently Director of the National Academy of Religion and Mental Health.[2] I judge them certainly to be God-conscious men, men of high moral convictions and possessing the courage of their convictions. Here and there I would be intellectually compelled to disagree with a conclusion; but honest and courteous difference of opinion need never make enemies or imply disrespect, even among theologians.

Just as it is unfortunately true that the Catholic doctor is not necessarily impeccable because of his affiliation with Catholicism, so is it undeniably true that the non-Catholic doctor is not, and is not considered to be, a moral villain merely because he disassociates himself from Catholicism.

Another source of misunderstanding in this sphere of medico-morality is the conviction of some that the Catholic Church, either officially in the person of her supreme authority or very unofficially in the persons of her private theologians, is guilty not only of unjustifiable intervention, but even of obstructionism, when she applies the moral law to medical problems. I refer to that conviction as a misunderstanding, and before I attempt to resolve it, let me ask you to make one or two concessions which should not be difficult.

Can we agree that if God's eternal law puts restrictions on certain

[1] "Religion and Medicine — Allies or Adversaries?" *GP* 14 (Sept., 1956) 75-81.

[2] "Conflicts Between Psychiatry and Religion," *J.A.M.A.* 155 (May 22, 1954) 335-39.

medical procedures, then those restrictions are properly imposed and are morally binding on the medical profession? If medical science were to deny that supposite, then medicine would be a godless and amoral profession. (And why, incidentally, should the doctor be answerable to any man for his professional activity if he were not first answerable to God?) Surely all of us will admit, for example, that it is ultimately the law of God, and not merely a humanly contrived prohibition, which protects human life from wanton attack. And just as surely no doctor worthy of his profession would seriously contend that innocent human life is not to be considered sacred in the hands of the physician.

Let me quote briefly from the Geneva version of the Hippocratic Oath as adopted by the World Medical Association: "The health and life of my patient will be my first consideration . . . I will maintain the utmost respect for human life from the time of its conception."[3] Do you and I speak the same language, or does that pledge to your mind represent something less than the medical profession's acknowledgment of one phase of God's moral law? When theologians refer to the natural law as it applies to medicine, that is all they mean: God's own law as it concerns the exercise of medical art and science.

This next point I must ask you to accept upon my word as an honest gentleman — to prove it adequately would take far more time than I am allowed. *The Catholic Church has never pronounced on medico-morality except with the conviction that she was expressing not her own human law but the law of God Himself.*

Now I ask the non-Catholics among you to accept on my word alone only the fact that that is her conviction, because that suffices for my present purpose. The truth of that conviction I cannot ask you to accept merely on my word; because I know, not only from personal intellectual experience but also from the teaching of my own Church, how difficult it is for human reason, left to its own devices, to perceive all the ramifications of what we call natural law.[4] And I would be false to my own Catholicism if I did not maintain that my faith is calculated to facilitate my own perception of natural law. But if one concedes that God's moral law applies also to medicine; and if one concedes that it is one function of churchmen to teach God's moral law, would not a church be derelict in her duty if she did not apply that law as she knows it to medical procedures?

Because I promised you in courtesy to avoid controversy, permit me to transmit the next obvious question, viz., by what right does

[3] Both the Declaration of Geneva and the International Code of Medical Ethics are reproduced in LINACRE QUARTERLY 22 (May, 1955) 56.

[4] Vatican Council, Session III, Ch. 1. Cf. also the encyclical *Humani generis* of Pope Pius XII (A. C. Cotter, S.J., *The Encyclical "Humani Generis,"* Weston, Mass.: Weston College Press). For a brief but most informative commentary on man's power to know the natural law, cf. G. Kelly, S.J., in LINACRE QUARTERLY 21 (Aug., 1954) 73-75.

the Catholic Church presume that her answers to these problems are necessarily correct? The answer to that question is irrelevant to my present purpose. I have been trying only to establish, on the basis of certain assumptions, that there is a legitimate place for the theologian in the field of medicine, and that the charge of unjustified trespassing is not an indictment wherein "res ipsa loquitur."

But is religion in this sense of morality an obstacle to the progress of medical science? Allow me for the moment to put aside theology and to talk in terms of medical values alone.

The persistent opposition of the Catholic Church to therapeutic abortion is common medical knowledge. It has occasioned some misunderstandings; it has provoked in some quarters this charge of obstructionism. One such misunderstanding has been expressed in the so-called mother-or-child dilemma, whereby it is alleged that in Catholic hospitals and according to Catholic teaching, the life of the mother must be sacrificed, if necessary, for that of the child. Merely in passing I would like to say that what we actually teach is rather this: the lives of both mother and child are equally sacred; neither life may be directly attacked in order to save the other. (Still in passing: do we talk the same language, or do you mean anything less than that when you pledge "the utmost respect for human life from the time of its conception"?)

The more pertinent point, however, is the medical issue. Is it not true that medicine at its best has exploded, or is at least in the process of exploding, the very foundation of the dilemma itself? Dr. Samuel Cosgrove whose work has distinguished him at the Margaret Hague Maternity Hospital and who is a non-Catholic is by no means alone in his contention that medical indications for therapeutic abortion are very rare, if not actually nil, and that the obstetrician who resorts to therapeutic abortion is practicing inferior medicine.[5] It seems to be the undeniable trend in obstetrical literature of recent years to reach that same conclusion. Have you yourselves not seen statistical studies which apparently prove that, when good obstetrics is practiced, the maternal death rate is no higher in hospitals which forbid therapeutic abortion than it is in hospitals which permit it? *A system of morality which decries therapeutic abortion can scarcely be called obstructionistic to a science which repudiates the very same practice!*

Let me cite another instance. It is likewise commonly known that Catholicism will not admit the licitness of direct sterilization for therapeutic reasons. More specifically, we maintain that routine sterilization after any specified number of cesareans is morally objectionable. Again on exclusively medical grounds, let me quote from the *Obstetrical and Gynecological Survey* of August, 1956. The editor,

[5] *Amer. J. Obs. and Gyn.*, Sept., 1944, pp. 299 ff.; *J.A.M.A.* 137 (May 22, 1948) 331-36. Cf. also R. J. Heffernan, M.D. and W. A. Lynch, M.D., "Is Therapeutic Abortion Scientifically Justified?" in LINACRE QUARTERLY 19 (Feb. 1952) 11-27.

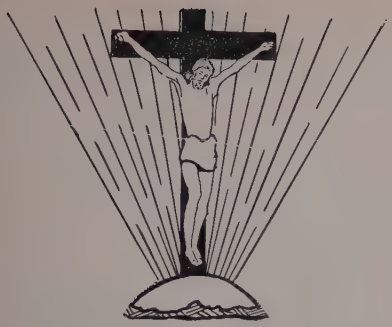
Dr. Nicholson J. Eastman, Professor of Obstetrics at Johns Hopkins University Medical School, is commenting on an article entitled "Patients with Four or More Cesarean Sections:"[6]

"The main theme of the paper is that uteri containing four or more cesarean scars are less likely to rupture in subsequent pregnancies than we have hitherto supposed. This thesis is convincingly supported by the following simple fact: Rupture through one of the old scars occurred in only two of these 130 cases or in only 1.5 per cent. To set a precise figure for the incidence of rupture in uteri which have been subjected to only one or two previous sections would be hazardous, but on the basis of recent reports the figure is probably not less than 1.0 per cent, in other words, not appreciably lower than the authors' figure for these uteri containing four to ten scars. This is a new and important fact to have established — a fact, it may be noted, which pretty well annihilates any real obstetrical basis for routine sterilization after the third section. Those of us who have followed this widespread policy may not like this revelation, but the important thing is to know the truth whether we like it or not. Only fools and dead men never change their minds."

Such challenges as these come not from theologians arguing from ethical principles, but from members of your own medical profession pleading the cause of the best possible medicine. It is their contention that most, if not all, therapeutic abortions are medically unacceptable; that the routine sterilization after a second or third section is not good obstetrics! Again I ask you: can one logically term obstructionistic to medicine an ethical principle which leads to a like conclusion?

There is, I can assure you, nothing incompatible between what is best in medical science and what is sound moral teaching. There should be no hostility between the physician as such and the moral theologian as such. Even if we understand religion in the restricted sense in which I have taken it, viz., as the virtue which inclines human nature to grant God the reverence and honor which is due Him, religion's relationship to good medicine is one of complete amicability. For religion does no more than ask of the physician in God's name what his profession expects of him in the name of true progressive science.

[6] H. F. McNally, M.D., and V. de P. Fitzpatrick, M.D., in *J.A.M.A.* 160 (Mar. 24, 1956) 1005-10.



The Mystery of Suffering

JEROME A. KELLY, O.F.M.

Father Kelly, a member of the Franciscan Province of the Holy Name, has been a priest since 1937 and is professor of English at St. Bonaventure University, St. Bonaventure, New York. As guest speaker at the "White Mass" to honor St. Luke on October 18, Father Kelly gave this sermon to the medical staff at St. Francis Hospital, Olean, New York. We wish to share the message with all of our readers. St. Francis is one of the many hospitals cooperating with the Federation in sponsoring the "White Mass" in their chapels on St. Luke's Day.

Among many differences between modern times and days gone by is the change in attitude towards mystery. Mystery used to be something actually not understood, but essentially understandable; something which did make sense on one level of intelligence, even though a lower level could not see how. Things that impressed a child as mysteries, for example, were not such for his parents. Whereas, in a grander sense, things transparently clear to God were mysteries for all His children.

But modern man has altered that view of mystery; mystery now is simply something he does not understand today, but will tomorrow. He pushes the matter to conclusion by insisting that anything not clearly comprehended ultimately by a majority of intelligent people is simply a delusion, a popular myth, a superstition more likely than not. It does not make sense, so he pays no attention to it, unless inconvenient, then he goes to work to stamp it out, to eliminate it.

And that is what you find him doing to suffering, where suffering stands for all pain — physical and spiritual — loneliness, sorrow, poverty, "the heart-ache and the thousand natural shocks that flesh is heir to." Moderns tend to think of suffering like that rather as an evil than as a mystery; and in that regard they differ radically from their ancestors.

When you look back over the history of our culture and examine the Classic thought and the Christian faith which figure so prominently in it, you discover a common recognition of suffering as a mystery, something which made sense even though the sufferer could not see as much. The literature of Greece is her monument

and memorial, and supreme among its works are the great tragedies. Nowhere else have human pain, anguish, bodily ills and the spiritual sorrows been more compellingly described and dramatized. And what makes these tragic masterpieces unforgettable is their insistence that man cannot abolish or eliminate suffering; he can face and bear up under suffering, as a mystery somehow implicated with the will of his gods.

What the Greek mind groped for in these tragedies, the Christian discovered in the Gospel. The "good news" of Christianity, in fact, centered upon the mystery of suffering, incarnate in the person of Jesus Christ, Who, precisely because "he has been tried by suffering . . . has power to help us (Hebrews 2:18)." The Christian was united with this suffering Saviour, and becomes one with his brothers in a Mystical Body whose Head is the Crucified Christ. This incorporation helped the Christian to accept the mystery of suffering and to be saved through it. First, it was through suffering he had his chance to show his love for Christ; the sufferer — the poor, the needy, the sick and the sorrowful — was Christ and when a Christian befriended and consoled "even the least of these" he did it to Christ. Then, the very act of Christian faith and love, too, made *you* the better for it; in order to see Christ in others, you had to be Christ yourself, you had to realize the boast of Saint Paul: "It is now not I who lives, but Christ lives in me (Gal. 2:20)." Finally, consciousness of such intimate union with Christ further strengthened him to accept his personal suffering and to make his own those other words of St. Paul: "I rejoice now in the sufferings I bear . . . and what is lacking of the sufferings of Christ I make up in my flesh for His body which is the Church (Col. 1:24)."

Actually, suffering was not so much a mystery for the Christian; it was the logical consequence of sin. *There* was the mystery, the mystery of evil so tremendous that it occasioned the Incarnation of Jesus Christ "who dispossessed himself, and took the nature of slave, . . . lowered his own dignity, accepted an obedience which brought him to suffer death on the cross (Phil. 2:7-8)." What Christianity did was to validate the surmise of the Greek that there was something religious about suffering. Christianity announced, in fact, that through suffering with Christ each individual could play a part in the great drama of salvation from sin. But, of course, that Christian concept, which brought the Greek attitude to fulfillment, cannot be popular today, would not be acceptable to a world that has denied sin and all but despaired of salvation.

It is most fitting, however, that I commend this Christian attitude to members of your profession on the feast of Saint Luke, "the beloved physician (Col. 4.14)," as Saint Paul called him. He so symbolizes it that his life becomes practically a text for three points.

First, the Catholic doctor *thinks* of suffering, fundamentally, and essentially, as one of the effects of

sin. I do not mean that in any shortsighted way, as though suffering were the immediate result of sin as indigestion is the consequence of gluttony; or as though suffering were the penalty for one's personal sin as gout torments the aging *bon vivant*. No, I mean that suffering is a result of sin in this deeper sense; it is an abiding concomitant of the human condition, the penalty for *being* human and so, lasting as long as man is man. It is the perpetuation of the passion of Christ, enduring among the members of His Mystical Body, holding its sway until the redemption of the race is consummated.

Secondly, and as a kind of corollary of the first position, the Catholic doctor adopts a *practical attitude* towards suffering. He does not undertake the task of scientifically eliminating it, but of sympathetically alleviating it. And he accomplishes this purpose by doing all he can to bring it within the power of humans to bear — for there is a point beyond which no human can go, a point where even Jesus prays, "If it be possible let this chalice pass from me. (Lk. 22:42)." More importantly, however, he fulfills this purpose by helping his patients bear that share of suffering every human must bear; by doing everything in his power to help them say with Christ: "Not my will, but thy will be done. (Lk. 22:42)."

This means, of course, that his contribution is as much what he does for his patient's spirit as what he does for his body. The patient never becomes merely a problem; he is always and first of all a person. While the good doctor will neglect nothing that will make his examination professionally thorough, his diagnosis scientifically exact, his prescription adequate beyond question, he will, and more importantly, be patient and understanding, genial and tender, kind and sympathetic. He will heed the words spoken at the dedication of one of Italy's most modern psychiatric hospitals by the man who inspired its foundation, Padre Pio: "You have the mission of curing sickness, but if you do not bring love to the sickbed, I do not think that medicine will do much good." In the richest sense of the words, he will depend for his best results on a "bedside manner" that, whether his patients know it or not, will resemble that of Christ who had "compassion on the multitude" of sufferers in His day.

Which brings me to the third point: the Catholic doctor has a *spiritual insight* into suffering which is his most powerful support. We know, especially from the experiences recorded in treatment of psychiatric cases, how therapeutically valuable is the bearing and the conduct of the psychiatrist himself. So it is with any doctor to a certain extent; his most beneficial effect upon his patients is a spiritual thing, deeper than the effect produced by his pills and prescriptions; it is a tranquilizing, soothing, stabilizing effect upon those he treats. It is a radiation of his own spiritual adjustment to the mystery of suffering. If he himself is interiorly tense, edgy, baffled, perhaps frustrated, because he is dedicated only to the elimination

of pain and suffering, his patients will subtly be infected by his attitude. If he is calm, tranquil, strongly confident in the help of Christ to alleviate pain and to make it bearable for spiritual motives, his patients will reflect his attitude — the multitude will be eager to come to him, because, like Christ, "power will go out from him" to heal them (Lk. 6:19).

That is why a doctor, like a priest, and in imitation of St. Luke who was both, must accept the mystery of suffering. Surely he must work, conscientiously and effectively, to lessen the suffering of the world — even though the minimum which must remain will always have staggering and shocking proportion. That minimum he must accept and really want because he sees it as the chance God gives to every man to take up the cross and follow in the footsteps of Jesus. That minimum he must accept and treasure gratefully because he knows it is the surest way he has of helping Christ in "the least of these" suffering brethren. That minimum he must accept and love because it offers him the richest opportunity to be Christ by saying to sufferers — the sick, the needy, the sad, the dispirited and baffled, the lonely and the weak, the words of his Master: "Come to me, all you that labor and are burdened; I will give you rest (Mt. 11:28)," through Jesus Christ, Our Lord. Amen.

Executive Board
Federation of Catholic Physicians' Guilds
Winter Meeting — 1956

The winter meeting of the Executive Board of The Federation of Catholic Physicians' Guilds was held in Cleveland, Ohio, December 8 and 9, 1956, at Hotel Statler. The following were present:

M. F. Yeip, M.D. — President
W. J. Egan, M.D. — First Vice-President, also Boston Guild
E. J. Murphy, M.D. — Third Vice-President, also Bronx Guild
Rt. Rev. Msgr. D. A. McGowan — Moderator
Rev. Henry M. Gallagher — Moderator, Canton Guild
Msgr. F. W. Carney — Moderator, Cleveland Guild

R. M. Eiben, M.D. — Cleveland Guild
G. P. G. Griffin, M.D. — Brooklyn Guild
D. J. Hughson, M.D. — Milwaukee Guild
R. P. Carney, M.D. — Davenport Guild
D. A. Mulvihill, M.D. — New York Guild
J. F. O'Neill, M.D. — Philadelphia Guild
C. F. Berg, M.D. — Pittsburgh Guild
J. C. Muccigrosso, M.D. — Westchester Guild

M. R. Kneifl — Executive Secretary
Jean Read — Assistant Secretary

The meeting was called to order at 9:30 a.m.

After roll call, the President requested vote on the minutes of the Executive Board Meeting, June 13, 1956, in Chicago, Illinois, as read by the Executive Secretary. Approved as mailed.

President's Report

The President reported on the Federation booth at the A.M.A. convention held in Chicago during June 1956. This was an extremely successful "first" in the history of the Federation. Some 425 inquiry cards were signed, requesting information concerning the Catholic viewpoint on many moral issues in medical practice. All were acknowledged and processed to the limit of our ability. The display (which was highly impressive and in keeping with the dignity of our organization) was forwarded to St. Louis for storage and will be used again at the Convention in New York City, June 3-7, 1957. Officials of the American Hospital Association evidenced interest and extended an invitation to participate in the exhibits of their convention in September 1957.

The President further reported that Rt. Rev. Msgr. D. A. McGowan, moderator of the Federation, and Dr. John G. Muccigrosso, of the Westchester Guild, officially represented the Federation at the International Congress of Catholic Doctors at the Hague in September 1956.

The Dean of the Medical School and Professor of Pathology in Bombay, India visited the President during the year, advising that

there are Guilds in Patna, Delhi, and Calcutta. It is their wish to keep in touch with the American Guilds.

The Moderator's Report

Report on the International Congress of Catholic Doctors included mention of the fact that some 350 doctors from 20 countries were present. The registrants, along with their wives and children, added up to a fine group of slightly over 500. "Law and Medicine" was the theme. Some disappointment was noted because the emphasis at the International meeting was on theoretical problems rather than a down-to-earth discussion of the law as it relates to the practical everyday life of the Catholic doctor. The Holy Father broadcast a special message to the doctors in session via a closed circuit directly from Vatican City. A report was made by the Moderator of his visit to the Children's Hospital in Rome conducted by the Daughters of Charity of St. Vincent de Paul. This visit was significant principally because the hospital involved is the only one in the world under the direct jurisdiction and patronage of His Holiness Pope Pius XII.

The 1958 International Congress of Catholic Doctors will be held in Brussels. The World's Fair (a purely secular endeavor) will be held in Brussels the same year. The Vatican plans a special building to portray the life of the Catholic Church throughout the world. Our Federation of Catholic Physicians' Guilds will undoubtedly be asked to participate in a modest fashion.

Reference was made to the proposed principles of medical ethics to be discussed at the A.M.A. winter clinical sessions scheduled for Seattle, Washington. The proposed Code appeared in the December 11, 1956 issue of *Look* magazine; item n. 3 reading: "A physician should not base his practice on an exclusive dogma or a sectarian system, nor should he associate voluntarily with those who indulge in such practices," is in question and it was felt that the word "dogma" should be clarified. If the accepted draft includes this section without any change, it was recommended to contact the A.M.A. (Since these notes were written, the A.M.A. has changed the above quoted principle to read: "A physician should practice a system of healing founded only on a scientific basis. He should not voluntarily associate with those who violate this principle." This would definitely seem to eliminate any possibility of misinterpretation of the original proposal.)

Linacre Quarterly

The distribution of the November issue of the journal was reported to be 8,015. Some 3,600 copies of the total were mailed to members of Catholic Physicians' Guilds. It was decided to feature a new cover design for the magazine; a layout was submitted and approved by members of the Board. The names of several publishing houses were suggested to contact as possible advertisers in Linacre Quarterly.

It was decided to ask each Guild to be responsible for submitting at least one article yearly for publication in the journal, written by a member, an important paper given by a speaker, etc. To stimulate the interest of Catholic doctors to write, it was voted to establish an annual Thomas Linacre Award for the best article submitted during the year. To make the first award in 1957, a survey of articles written by Catholic doctors published in LINACRE QUARTERLY during the past five years will be made to determine the recipient. The award will be in the nature of a medal suitably engraved and the doctor will be the guest of the Federation at each June meeting of the Board to receive it.

It was voted to add the names of the Most Reverend Bishops to the LINACRE QUARTERLY mailing list to receive the journal regularly.

To provide added revenue for the Federation and its activities, motion was made and passed to increase the subscription rate of LINACRE QUARTERLY for Guild members from $1.50 a year to $2.00, the same as for all other subscribers, effective January 1, 1957.

MEMBERSHIP REPORT

The number of affiliated Guilds comprising the Federation was reported as 58. Since the June 1956 meeting of the Board, four groups joined the Federation: Evansville, Indiana; Davenport, Iowa; Youngstown, Ohio, and Puerto Rico. Guilds pending were reported to be: Oklahoma City, Louisville, Peoria, Queens County, Staten Island, and Nassau-Suffolk County, New York; a second Guild in Philadelphia, and Alexandria, La.

PROMOTION OF GUILDS

To promote the organization of additional Guilds, it was suggested that a letter be sent to the Ordinaries of the United States giving Their Excellencies information about the growth of the Guilds with a view to stimulating organization where Catholic physicians do not have Guilds.

It was also suggested that articles be submitted to such special magazines as reach the attention of priests and that the Bishops' Representatives for Catholic hospitals be alerted concerning the aims and functions of the Guilds so that they might carry on this important apostolic work.

To give more responsibility to existing Guilds, it was suggested that representatives be appointed regionally to investigate possibilities of organizing groups in their geographical areas. These representatives would confer with the Executive Committee of the Federation and be the operating nucleus for future Guilds. This is being done in some dioceses of the United States at the present time.

Guilds are requested to send in to the central office the names of any priest-doctors of whom they have knowledge to accord them honorary membership in the Federation. The Moderator was asked to send a letter to all dioceses in the nation to obtain the names of priests who have medical degrees.

The "White Mass"

It was reported that the 1956 observance of the "White Mass" was the most widespread since the Federation began sponsoring it three years ago. The Mass was offered in many Cathedrals and parish churches, with the Bishop of the diocese as celebrant in many cities. Catholic hospitals in areas where there are no Guilds cooperated most generously in offering their chapels for the Mass. Press publicity for the occasion was generous and provided excellent promotion not only for the "White Mass" but also to inform the public regarding Catholic Physicians' Guilds.

A resume of the reports received at the central office was sent to each Guild.

Finances

The preliminary annual financial statement was presented, discussed and approved. A proposed budget for 1957 was submitted and approved. A copy of each report was mailed to the President and Moderator of each Guild.

June Meeting of Executive Board — 1957

It was voted to hold the June meeting of the Executive Board of the Federation on the 4th at 8:00 p.m., Waldorf-Astoria Hotel, New York. Election of officers will take place at this meeting.

Federation Exhibit — A.M.A. Convention 1957

For the second year, the Federation will participate in the exhibits of the American Medical Association Convention to be held in New York City, June 3-7. The booth will be staffed by Guild members. The Davenport, Iowa Guild will direct this project. Those wishing to volunteer hours of service are requested to write to the central office of the Federation, advising date and time available.

Silver Jubilee Observance

The 25th anniversary of the Federation of Catholic Physicians' Guilds will be observed on June 5, 1957 in New York City. The Committee appointed by the President, consisting of members of the Bronx, Brooklyn, New York, and Westchester Guilds submitted plans for the observance of the occasion. Members of the Board present voted to accept the arrangements. An anniversary Mass will be offered at St. Patrick's Cathedral at 9 or 9:30 a.m. In the evening it is proposed to hold a banquet in the Grand Ballroom of the Waldorf-Astoria Hotel. The seating capacity is 1,000. Music will be provided, a prominent guest speaker is to be engaged, and the dinner will be following by dancing. Dinner tickets will be $15.00 each.

To pay tribute to the Moderators of the Federation, in their honor a chalice will be given to the Medical Mission Sisters to be used in one of their mission chapels. Gavels will be presented to the past-Presidents of the Federation. The first Thomas Linacre Award will be conferred.

The Committee was authorized

to negotiate with the Waldorf-Astoria Hotel and make all necessary arrangements to carry out the plans.

In response to the request of O'Scannlain & English Travel Service, Shamrock Building, New York City, to be designated as the official agent of the Federation for transportation to New York for the Jubilee celebration, the Board approved this firm.

Meeting adjourned—12:30 p.m., December 9.

As LINACRE QUARTERLY goes to press we are happy to announce that General Carlos P. Romulo, Philippine Ambassador to the United States, has accepted our invitation to be the principal speaker at our Silver Jubilee Banquet at the Waldorf-Astoria Hotel.

General Romulo's acceptance gives the final touch to our program.

Silver Jubilee Celebration

Federation of Catholic Physicians' Guilds

THE OBSERVANCE of the twenty-fifth anniversary of the founding of The Federation of Catholic Physicians' Guilds will take place in New York City on Wednesday, June 5, 1957, during the week of the A.M.A. Convention. The Committee on Arrangements announces that plans are well under way for an outstanding celebration that will be public recognition of the Guilds and the entire Catholic medical profession of the United States and Canada.

His Eminence, Francis Cardinal Spellman, Archbishop of New York, notable for his deep interest in and support of the medical profession and hospitals, has graciously consented to be Honorary Chairman for the Silver Jubilee. The Honorary Committee will include well known members of the Hierarchy, the medical profession, and others prominent in education and civic affairs.

The Celebration will begin with the Anniversary Mass at 9:00 a.m. at St. Patrick's Cathedral. His Eminence, Francis Cardinal Spellman, will be the celebrant. The sermon will be preached by Reverend Ignatius Cox, S.J., of Fordham University, first Moderator of the Federation. It is expected that the Mass will be attended by all Catholic physicians and their families who are in New York for the A.M.A. Convention. It is anticipated that Guilds, hospital staffs, and Catholic medical school alumni groups will attend together. Special sections in the Cathedral for such groups, as well as individuals, may be reserved on request to the Silver Jubilee Committee on Arrangements.

The social event of the Celebration will be the Banquet and Ball to be held in the evening in the Grand Ballroom of the Waldorf-Astoria Hotel. His Eminence will grace the occasion, giving the Invocation and presiding on the dais for the guests of honor. The guest speaker will be one of national prominence, whose name will be announced at a later date. An outstanding program of musical entertainment is being arranged. One of the country's finest orchestras will furnish music during dinner and for the dancing to follow until 1:30 a.m.

The Federation extends a cordial invitation to ALL Catholic physicians, their wives, families and friends to participate in the events of the Silver Jubilee Celebration and hopes that those in New York for the A.M.A. Convention will attend. Guild membership is not a requisite.

Silver Jubilee

FEDERATION OF CATHOLIC PHYSICIANS' GUILDS

Honorary Committee

Chairman:

His Eminence, Francis Cardinal Spellman

Archbishop of New York

Vice-Chairmen:

Most Reverend Richard J. Cushing, D.D., Archbishop of Boston

Rt. Rev. Msgr. Donald A. McGowan
Moderator of the Federation

Rt. Rev. Msgr. John J. O'Donnell, P.A.
Exec. Dir., Alfred E. Smith Foundation

Reverend John J. Flanagan, S.J.
Editor, The Linacre Quarterly

Moderators Emeritus, The Federation
Reverend Ignatius Cox, S.J.
Reverend Alphonse Schwitalla, S.J.

Narcisse F. Thiberge, M.D.
Honorary President

Melvin F. Yeip, M.D.
President

William J. Egan, M.D.
First Vice-President

Past Presidents

Thomas M. Brennan, M.D.

John J. Masterson, M.D.

John W. Spellman, M.D.

William P. Chester, M.D.

Joseph J. Toland, M.D.

Committee on Arrangements

Chairman:

Daniel A. Mulvihill, M.D.
New York Guild

Vice-Chairmen:

Eusebius J. Murphy, M.D., Bronx Guild

Gerard Griffin, M.D., Brooklyn Guild

John G. Muccigrosso. M.D.,
Westchester Guild

J. MacFarlane, M.D., Queens Guild

James Corcoran, M.D., Nassau-Suffolk Guild

Treasurer:

Leo Kennedy, M.D., New York Guild

Assistant Treasurer:

James T. Geddis, M.D., Bronx Guild

Committeemen:

James T. Sutter, M.D., Bronx

W. P. Clark, M.D., Westchester

John J. Masterson, M.D., Brooklyn

John F. Raycroft, M.D., Brooklyn

John M. Scannell, M.D., Queens

Daniel Bradley, M.D., Nassau-Suffolk

Maurice C. O'Shea, M.D., New York

James Daniels, M.D., New York

John L. Madden, M.D., New York

Emil Naclerio, M.D., New York

Alfred J. Vignec, M.D., New York

Luke Mulligan, M.D., New Jersey

Harold A. Murray, M.D., New Jersey

George N. Sommer, Jr., M.D.,
New Jersey

Arthur Mannix, Jr., M.D., Westchester

Vincent P. Butler, M.D., New Jersey

Robert Hicks, M.D., New York

Bernard Pisani, M.D., New York

(To be completed)

PROGRAM

FEDERATION OF CATHOLIC PHYSICIANS' GUILDS

Silver Jubilee

WEDNESDAY, JUNE 5, 1957
NEW YORK CITY

9:00 a. m.

PONTIFICAL ANNIVERSARY MASS
ST. PATRICK'S CATHEDRAL

Celebrant

HIS EMINENCE, FRANCIS CARDINAL SPELLMAN
ARCHBISHOP OF NEW YORK

Sermon

REVEREND IGNATIUS COX, S.J.
FIRST MODERATOR OF THE FEDERATION OF
CATHOLIC PHYSICIANS' GUILDS

* * * *

6:30 p. m.

BANQUET

GRAND BALLROOM, HOTEL WALDORF-ASTORIA

RECEPTION

DINNER

Honorary Chairman

HIS EMINENCE, FRANCIS CARDINAL SPELLMAN
ARCHBISHOP OF NEW YORK

ADDRESS OF THE EVENING

ENTERTAINMENT AND DANCING

Cordial invitation is extended to ALL Catholic physicians, their wives and guests

ADDRESS:

SILVER JUBILEE COMMITTEE
Federation of Catholic Physicians' Guilds
453 Madison Ave., New York 22, New York

BANQUET RESERVATIONS *will be $15.00 per person to include reception, dinner, dancing and gratuities. Tables seating ten may be reserved. Guilds, hospital staffs, and Catholic medical school alumni may wish to reserve tables together. Every effort will be made by the Committee on Arrangements to accommodate such groups. Guild or group representatives should advise the Chairman, Silver Jubilee Committee, as early as possible of their expected requirements.*

Address inquiries to:

CHAIRMAN, SILVER JUBILEE COMMITTEE
DANIEL A. MULVIHILL, M.D.
FEDERATION OF CATHOLIC PHYSICIANS' GUILDS
453 MADISON AVENUE
NEW YORK 22, NEW YORK

Please use this form for reservations.

RESERVATION FORM

Silver Jubilee Banquet and Ball

FEDERATION OF CATHOLIC PHYSICIANS' GUILDS
HOTEL WALDORF-ASTORIA, N. Y.
WEDNESDAY, JUNE 5, 1957

RESERVATIONS — $15.00 PER PERSON

Enclosed check in amount of $..... is for ..... Tickets.

Please arrange seating with

☐ Guild .....

☐ Hospital .....

☐ Medical School Alumni of .....

☐ Choice of the Committee

☐ Enclosed is check in amount of $150.00. Please reserve table for ten in my name.

Please send tickets to: .....

Address: .....

MAKE CHECKS PAYABLE TO: Silver Jubilee Committee, F.C.P.G.